		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044602

Facility Name: OAK PARK HEALTHCARE CENTER

Address: 625 N HARLEM (Number) OAK PARK (City) 60302 (Zip Code)

County: WILL

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4303161

Date of Initial License for Current Owners: 11/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code			Corporation		Other		
			"Sub-S" Corp.				
		X	Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) MANAGER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	176	Skilled (SNF)	176	64,240	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,220	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,188		3,359	4,547	8
9	SNF/PED					9
10	ICF	43,427	1,943		45,370	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,615	1,943	3,359	49,917	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.04%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 3,359

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	192,836	22,927	11,135	226,898		226,898	1,032	227,930			1
2	Food Purchase		210,220		210,220	(14,235)	195,985	(607)	195,378			2
3	Housekeeping	135,864	28,096		163,960		163,960		163,960			3
4	Laundry	67,945	14,915		82,860		82,860		82,860			4
5	Heat and Other Utilities			122,614	122,614		122,614	421	123,035			5
6	Maintenance	45,508	24,293	30,594	100,395		100,395	11,662	112,057			6
7	Other (specify):*			9,996	9,996		9,996		9,996			7
8	**TOTAL General Services**	442,153	300,451	174,339	916,943	(14,235)	902,708	12,508	915,216			8
	B. Health Care and Programs											
9	Medical Director			1,500	1,500		1,500		1,500			9
10	Nursing and Medical Records	1,657,822	91,371	18,784	1,767,977		1,767,977	32,646	1,800,623			10
10a	Therapy	46,506	4,240	58,507	109,253		109,253	976	110,229			10a
11	Activities	78,110	9,669	689	88,468		88,468		88,468			11
12	Social Services	94,862		4,348	99,210		99,210		99,210			12
13	Nurse Aide Training											13
14	Program Transportation			1,235	1,235		1,235		1,235			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,877,300	105,280	85,063	2,067,643		2,067,643	33,622	2,101,265			16
	C. General Administration											
17	Administrative	117,774			117,774		117,774	53,802	171,576			17
18	Directors Fees											18
19	Professional Services			295,998	295,998		295,998	(204,819)	91,179			19
20	Dues, Fees, Subscriptions & Promotions			64,040	64,040		64,040	(5,973)	58,067			20
21	Clerical & General Office Expenses	81,962	9,123	185,080	276,165		276,165	(81,224)	194,941			21
22	Employee Benefits & Payroll Taxes			373,876	373,876	14,235	388,111		388,111			22
23	Inservice Training & Education			1,839	1,839		1,839	1,019	2,858			23
24	Travel and Seminar			100	100		100	408	508			24
25	Other Admin. Staff Transportation			442	442		442	2,878	3,320			25
26	Insurance-Prop.Liab.Malpractice			165,296	165,296		165,296	4,330	169,626			26
27	Other (specify):*							39,986	39,986			27
28	**TOTAL General Administration**	199,736	9,123	1,086,671	1,295,530	14,235	1,309,765	(189,593)	1,120,172			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,519,189	414,854	1,346,073	4,280,116		4,280,116	(143,463)	4,136,653			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER #0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			33,918	33,918		33,918	333	34,251			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			159,454	159,454		159,454	33,384	192,838			32
33	Real Estate Taxes			353,218	353,218		353,218		353,218			33
34	Rent-Facility & Grounds			935,856	935,856		935,856	8,578	944,434			34
35	Rent-Equipment & Vehicles			68,822	68,822		68,822	(7,425)	61,397			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,551,268	1,551,268		1,551,268	34,870	1,586,138			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		165,353	195,026	360,379		360,379	(26,544)	333,835			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,691	111,691		111,691		111,691			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		165,353	306,717	472,070		472,070	(26,544)	445,526			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,519,189	580,207	3,204,058	6,303,454		6,303,454	(135,137)	6,168,317			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,274)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(607)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,506)	20		17
18	Fines and Penalties	(24,924)	21		18
19	Entertainment				19
20	Contributions	(450)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,675)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(853)	20		28
29	Other-Attach Schedule PAGE 5A	(17,117)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (64,406)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(70,731)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (70,731)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (135,137)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

OAK PARK HEALTHCARE CENTER

ID# 0044602

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 317	6	1
2	MARKETING SALARIES	(17,434)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(17,117)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	1,032	0	0	0	0	0	0	0	0	0	1,032	1
2	Food Purchase	(607)	0	0	0	0	0	0	0	0	0	0	(607)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	421	0	0	0	0	0	0	0	0	0	421	5
6	Maintenance	317	11,345	0	0	0	0	0	0	0	0	0	11,662	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(290)	12,798	0	0	0	0	0	0	0	0	0	12,508	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	32,646	0	0	0	0	0	0	0	0	0	32,646	10
10a	Therapy	0	8,939	(7,963)	0	0	0	0	0	0	0	0	976	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	41,585	(7,963)	0	0	0	0	0	0	0	0	33,622	16
	C. General Administration													
17	Administrative	0	53,802	0	0	0	0	0	0	0	0	0	53,802	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(204,819)	0	0	0	0	0	0	0	0	0	(204,819)	19
20	Fees, Subscriptions & Promotions	(8,484)	0	2,511	0	0	0	0	0	0	0	0	(5,973)	20
21	Clerical & General Office Expenses	(42,358)	(122,400)	83,534	0	0	0	0	0	0	0	0	(81,224)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,019	0	0	0	0	0	0	0	0	1,019	23
24	Travel and Seminar	0	0	408	0	0	0	0	0	0	0	0	408	24
25	Other Admin. Staff Transportation	0	0	2,878	0	0	0	0	0	0	0	0	2,878	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,330	0	0	0	0	0	0	0	0	4,330	26
27	Other (specify):*	0	0	39,986	0	0	0	0	0	0	0	0	39,986	27
28	**TOTAL General Administration**	(50,842)	(273,417)	134,666	0	0	0	0	0	0	0	0	(189,593)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,132)	(219,034)	126,703	0	0	0	0	0	0	0	0	(143,463)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(13,274)	0	13,607	0	0	0	0	0	0	0	0	333	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	33,384	0	0	0	0	0	0	0	0	33,384	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	8,578	0	0	0	0	0	0	0	0	8,578	34
35	Rent-Equipment & Vehicles	0	(15,371)	7,946	0	0	0	0	0	0	0	0	(7,425)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,274)	(15,371)	63,515	0	0	0	0	0	0	0	0	34,870	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(26,544)	0	0	0	0	0	0	0	0	(26,544)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	(26,544)	0	0	0	0	0	0	0	0	(26,544)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(64,406)	(234,405)	163,674	0	0	0	0	0	0	0	0	(135,137)	45

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					NILES	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	35	COMPUTER LEASE	$ 15,371	CAREPLUS MGMT INC		$	$ (15,371)	1
2	V	19	ADMIN. CONSULTANT FEES	198,000	" "			(198,000)	2
3	V	19	DATA PROCESSING FEES	14,400	" "			(14,400)	3
4	V	21	CLERICAL FEES	122,400	" "			(122,400)	4
5	V	1	DIETARY CONSULTANT FEES	7,200	" "			(7,200)	5
6	V	1	DIETARY SALARIES		" "		8,232	8,232	6
7	V	5	ELECTRICITY		" "		421	421	7
8	V	6	REPAIRS		" "		1,001	1,001	8
9	V	6	MAINTENANCE SALARIES		" "		10,344	10,344	9
10	V	10	NURSING		" "		32,646	32,646	10
11	V	10a	THERAPY SALARIES		" "		8,939	8,939	11
12	V	17	ADMIN SALARIES		" "		53,802	53,802	12
13	V	19	PROFESSIONAL FEES		" "		7,581	7,581	13
14	Total			$ 357,371			$ 122,966	$ * (234,405)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	DUES/LICENSES/WANT ADS	$	CAREPLUS MGMT INC		$ 2,511	$ 2,511	15
16	V	21	OFFICE SALARIES/EXPENSES		" "		83,534	83,534	16
17	V	23	SEMINARS		" "		1,019	1,019	17
18	V	24	TRAVEL		" "		408	408	18
19	V	25	TRANSPORTATION		" "		2,878	2,878	19
20	V	26	INSURANCE		" "		4,330	4,330	20
21	V	27	EMPLOYEE BENEFITS		" "		39,986	39,986	21
22	V	30	SL DEPRECIATION		" "		13,607	13,607	22
23	V	32	INTEREST		" "		33,384	33,384	23
24	V	34	OFFICE RENT		" "		8,578	8,578	24
25	V	35	EQUIP RENT/AUTO LEASE		" "		7,946	7,946	25
26	V								26
27	V								27
28	V								28
29	V	10a	THERAPY SERVICES	58,506	CAREPLUS REHABILITATIVE SERVICES		50,543	(7,963)	29
30	V	39	ANCILLARY THERAPY	195,026	" "		168,482	(26,544)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 253,532			$ 417,206	$ * 163,674	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCI	50.00	SEE ATTACHED	5.2	8.61	SALARY	15,928	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	50.00	SCHEDULES	5.2	8.61	" "	15,928	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 31,856		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	459,177	9 FACILITIES	$ 75,722	$	49,917	$ 8,232	1
2	5	ELECTRICITY	" "	579,760	13 FACILITIES	4,894		49,917	421	2
3	6	REPAIRS	" "	579,760	13 FACILITIES	11,630		49,917	1,001	3
4	6	MAINTENANCE SALARIES	" "	579,760	13 FACILITIES	120,135	120,135	49,917	10,344	4
5	10	NURSING	" "	579,760	13 FACILITIES	379,168	379,168	49,917	32,646	5
6	10a	THERAPY SALARIES	" "	579,760	13 FACILITIES	103,831	100,459	49,917	8,939	6
7	17	ADMIN SALARIES	" "	579,760	13 FACILITIES	624,886		49,917	53,802	7
8	19	PROFESSIONAL FEES	" "	579,760	13 FACILITIES	88,050		49,917	7,581	8
9	20	DUES/LICENSES/WANT ADS	" "	579,760	13 FACILITIES	29,166		49,917	2,511	9
10	21	OFFICE SALARIES/EXPENSES	" "	579,760	13 FACILITIES	970,207	726,859	49,917	83,534	10
11	23	SEMINARS	" "	579,760	13 FACILITIES	11,834		49,917	1,019	11
12	24	TRAVEL	" "	579,760	13 FACILITIES	4,741		49,917	408	12
13	25	TRANSPORTATION	" "	579,760	13 FACILITIES	33,424		49,917	2,878	13
14	26	INSURANCE	" "	579,760	13 FACILITIES	50,288		49,917	4,330	14
15	27	EMPLOYEE BENEFITS	" "	579,760	13 FACILITIES	464,414		49,917	39,986	15
16	30	SL DEPRECIATION	" "	579,760	13 FACILITIES	158,032		49,917	13,607	16
17	32	INTEREST	" "	579,760	13 FACILITIES	387,734		49,917	33,384	17
18	34	OFFICE RENT	" "	579,760	13 FACILITIES	99,626		49,917	8,578	18
19	35	EQUIP RENT/AUTO LEASE	" "	579,760	13 FACILITIES	92,291		49,917	7,946	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,710,073	$ 1,326,621		$ 321,147	25

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC						$	$			$ 33,384	1
2												2
3	ERIC ROTHNER		X		DEMAND	Nov-99	510,000	510,000				3
4	CAREPLUS MGMT - CIB BK	X		CAPL IMPR LOAN FEES	5 YR AMORT	2/23/01	2,475	1,567	3/23/06		495	4
5	CAREPLUS MGMT - CIB BK	X		CAPITAL IMPROVEMENT	$10,426.58	2/23/01	495,000	328,575	3/23/06	PRIME+	30,915	5
	Working Capital											
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND	Nov-99	1,925,000	2,370,000		PRIME+	124,273	6
7	INSURANCE FINANCING		X	INSUR. FINANCE							3,771	7
8												8
9	TOTAL Facility Related				$10,426.58		$ 2,932,475	$ 3,210,142			$ 192,838	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,932,475	$ 3,210,142			$ 192,838	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 298,780	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 324,378	2
3. Under or (over) accrual (line 2 minus line 1).		$ 25,598	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 327,620	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 353,218	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	286,264	8
	1998	292,508	9
	1999	285,617	10
	2000	295,825	11
	2001	324,378	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAK PARK HEALTHCARE CENTER COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0044602

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-07-106-004-0000	NURSING HOME	$ 64,671.66	$ 64,671.66
2.	16-07-106-005-0000	NURSING HOME	$ 61,883.61	$ 61,883.61
3.	16-07-106-022-0000	NURSING HOME	$ 197,822.45	$ 197,822.45
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 324,377.72	$ 324,377.72

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,926 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2+BASEMENT/ 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	22,950		$	1
2					2
3	TOTALS	22,950		$	3

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NEW WINDOWS / LIGHT FIXTURES / GENERATOR			1999	74,653	1,914	39	1,914		5,837	9
10	WINDOWS / FENCE / CEILING			2000	13,360	486	27.5	486		1,438	10
11	WINDOWS / SIGNS / FLOORING / WALLPAPER			2000	42,672	1,552	27.5	1,552		4,435	11
12	WINDOWS /FLOORING /WALLPAPER / NURSE STATION			2000	29,709	1,080	27.5	1,080		2,925	12
13	FLOORING / DOORS /WALLS /HVAC SYSTEM			2000	56,310	2,047	27.5	2,047		5,374	13
14	WINDOWS / FLOORING / RAILS / ASPHALT PAVING			2000	30,160	1,096	27.5	1,096		2,746	14
15	WINDOWS / PLUMBING / PAINTING & DECORATING			2000	41,459	1,508	27.5	1,508		3,404	15
16	WINDOW TREATMENTS			2000	15,445	2,701	15	1,030	(1,671)	2,575	16
17	WINDOWS/WALK-IN FREEZER, ROOF & A/C REPAIRS			2001	23,850	868	27.5	868		1,460	17
18	WINDOWS//FLOORING/ALARM & PAGING SYSTEM			2001	9,926	361	27.5	361		399	18
19	WINDOWS/DOORS/GREASE TRAP/ROOF A/C			2002	62,212	1,139	27.5	1,139		1,139	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT					101		101			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 399,756	$ 14,853		$ 13,182	$ (1,671)	$ 31,732	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 98,818	$ 17,733	$ 7,365	$ (10,368)	8-15 YRS	$ 18,450	71
72	Current Year Purchases	3,527	1,433	198	(1,235)	8-10 YRS	198	72
73	Fully Depreciated Assets							73
74	** RELATED PARTY - ALLOCATED SL DEPN: CAREPLUS MGMT, 13,506		13,506	13,506				74
75	TOTALS	$ 102,345	$ 32,672	$ 21,069	$ (11,603)		$ 18,648	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 502,101	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 47,525	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 34,251	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (13,274)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 50,380	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FAIRMOUNT OF OAK PARK LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		204	11/01/99	$ 935,856			3
4	Additions							4
5								5
6								6
7	TOTAL		204		$ 935,856 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 11/01/99
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2003	$
13.	12/31/2004	$
14.	12/31/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 61,277 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMIN,BANKING,	FACILITY VAN	$ 679.69	$ 7,545	17
18	PURCHASING,				18
19	ACTIVITIES,ETC				19
20					20
21	TOTAL		$ 679.69	$ 7,545	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 89,357	$		$ 89,357	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,160			2,160	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			97,299			97,299	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				91,696		91,696	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2 / 39-3				6,210	67,950		74,160	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					5,707		5,707	13
14	TOTAL			$		$ 195,026	$ 165,353		$ 360,379	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER **#** 0044602 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 71,641	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,331,816		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,072		6
7	Other Prepaid Expenses	13,480		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX ESCROW	266,466		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,743,475	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	384,868		15
16	Equipment, at Historical Cost	132,197		16
17	Accumulated Depreciation (book methods)	(93,908)		17
18	Deferred Charges	442,353		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 865,510	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,608,985	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 469,722	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,974		28
29	Short-Term Notes Payable	2,370,000		29
30	Accrued Salaries Payable	58,948		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,917		31
32	Accrued Real Estate Taxes(Sch.IX-B)	327,620		32
33	Accrued Interest Payable	100,053		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,375,234	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	838,575		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 838,575	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,213,809	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,604,824)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,608,985	$	48

***(See instructions.)**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,201,772)	1
2	Restatements (describe):		2
3	POST-CLOSING INTEREST EXPENSE	(29,770)	3
4	POST-CLOSING ALLOWANCE FOR BAD DEBTS	(50,000)	4
5	ROUNDING	10	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,281,532)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(323,292)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (323,292)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,604,824)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,986,244	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,986,244	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	17,348	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 17,348	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	800	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 800	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,004,393	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	916,943	31
32	Health Care	2,067,643	32
33	General Administration	1,295,530	33
	B. Capital Expense		
34	Ownership	1,551,268	34
	C. Ancillary Expense		
35	Special Cost Centers	360,379	35
36	Provider Participation Fee	111,691	36
	D. Other Expenses (specify):		
37	OUT OF PERIOD EXPENSES	24,231	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,327,685	40
41	**Income before Income Taxes (line 30 minus line 40)****	(323,292)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (323,292)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,324	2,664	$ 74,170	$ 27.84	1
2	Assistant Director of Nursing	1,532	1,532	37,946	24.77	2
3	Registered Nurses	19,261	20,267	440,271	21.72	3
4	Licensed Practical Nurses	21,323	21,668	413,815	19.10	4
5	Nurse Aides & Orderlies	72,214	77,386	672,647	8.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,316	5,474	46,506	8.50	8
9	Activity Director	2,172	2,356	25,891	10.99	9
10	Activity Assistants	7,571	7,920	52,219	6.59	10
11	Social Service Workers	5,711	5,923	94,862	16.02	11
12	Dietician					12
13	Food Service Supervisor	1,856	1,915	30,960	16.17	13
14	Head Cook	5,434	5,771	59,782	10.36	14
15	Cook Helpers/Assistants	13,235	13,651	102,094	7.48	15
16	Dishwashers					16
17	Maintenance Workers	4,312	4,486	45,508	10.14	17
18	Housekeepers	17,130	18,277	135,864	7.43	18
19	Laundry	8,594	9,213	67,945	7.37	19
20	Administrator	2,070	2,255	76,144	33.77	20
21	Assistant Administrator	2,075	2,203	41,630	18.90	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,434	5,806	64,528	11.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,685	1,765	18,973	10.75	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING	814	821	17,434	21.24	33
34	TOTAL (lines 1 - 33)	200,063	211,353	$ 2,519,189 *	$ 11.92	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,200	1-3	35
36	Medical Director	O	1,500	9-3	36
37	Medical Records Consultant	N	2,112	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,200	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	689	11-3	44
45	Social Service Consultant	E	4,348	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 31,449		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	38	$ 870	10-3	50
51	Licensed Practical Nurses	34	612	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	72	$ 1,482		53

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SAM BIBER	ADMIN	0	$ 25,658
GLORIA GREEN	ADMIN	0	50,486
COLLEEN BOTTENS	ASST ADMIN	0	18,252
KEVIN MEALS	ASST ADMIN	0	23,378
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 117,774

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT	DATA PROC	$ 14,400
CAREPLUS MGMT	ADMIN CONSULT	198,000
NATIONAL DATACARE	DATA PROC	2,610
AMERICAN DATA	DATA PROC	2,481
KBKB	ACCT	27,800
MEYER MAGENCE	LEGAL	9,050
KEANE & KEANE	LEGAL	10,000
CSC	LEGAL	265
PERSONNEL PLANNERS	UNEMPL CONSULT	3,142
RICHARD PEELO	M/C COST REPORT	3,750
FIRST REAL ESTATE SVC	APPRAISAL	3,500
SACHNOFF & WEAVER	LEGAL	21,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 295,998

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,086
Unemployment Compensation Insurance	41,076
FICA Taxes	191,195
Employee Health Insurance	80,463
Employee Meals	14,235
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,259
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	21,797
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 388,111

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	40,254
Health Care Worker Background Check	28
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	6,528
TRUST/FRANCHISE/CONTRIB/ETC	1,956
LICENSES & PERMITS	2,258
DUES & SUBSCRIPTIONS	12,816
MGMT CO ALLOCATION	2,511
TRUST/FRANCHISE/CONTRIB/ETC	(1,956)
Less: Public Relations Expense	(0)
Non-allowable advertising	(5,675)
Yellow page advertising	(853)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 58,067

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
IN-STATE LODGING	100
MGMT CO ALLOCATION	408
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 508

**See instructions.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	2000	$ 2,070	3	$	$ 345	$ 690	$ 690	$ 345	$	$	$	$
2	PAINT/DECORATING	2001	2,847	3			475	949	949	474			
3	PAINT/DECORATING	2002	1,587	3				265	529	529	264		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 6,504		$	$ 345	$ 1,165	$ 1,904	$ 1,823	$ 1,003	$ 264	$	$

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $11,016**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,623** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **111,691**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **14,235** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: OAK PARK HEALTHCARE CENTER #0044602 **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,200	
	REPAIRS & MAINTENANCE		3,935	
			0	11,135
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		36,032	
	ELECTRICITY		51,598	
	WATER		34,984	
	CABLE TV - LOBBY		0	
			0	122,614
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,227	
	PAINTING & DECORATING		1,587	
	BUILDING REPAIRS		3,408	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		13,801	
	ELEVATOR MAINTENANCE & REPAIR		3,912	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,025	
	FIRE SERVICE		2,634	
			0	
			0	
			0	30,594
7	**OTHER**			
	SCAVENGER		9,996	
	SECURITY SERVICE		0	9,996
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	1,500	1,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	1,482	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,112	
	PHARMACY CONSULTANT	XVIII B 39-2	1,200	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL SERVICES		13,990	
			0	18,784
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		14,540	
	SPEECH THERAPY SERVICES		1,134	
	OCCUPATIONAL THERAPY SERVICES		11,403	
	THERAPY CONTRACT SERVICES		17,030	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	58,507
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	689	
			0	689
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,348	
			0	4,348
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number OAK PARK HEALTHCARE CENTER **#0044602** **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,235	1,235
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	19,491	
	ADMINISTRATIVE CONSULTANTS	XIX C	198,000	
	PROFESSIONAL FEES	XIX C	78,507	
			0	295,998
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	5,675	
	EMPLOYEE WANT ADS	XIX F	40,254	
	CONTRIBUTIONS	VI 20 XIX F	50	
	DUES & SUBSCRIPTIONS	XIX F	12,816	
	LICENSES & PERMITS	XIX F	2,458	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	853	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	1,506	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	400	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	28	64,040
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		8,267	
	OUTSIDE CLERICAL SERVICES		122,400	
	PENALTIES / OVERDRAFT CHARGES	VI 18	24,924	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		245	
	TELEPHONE		28,108	
	MESSENGER SERVICE		1,136	
			0	185,080

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	191,195	
	UNEMPLOYMENT COMPENSATION	XIX D	41,076	
	WORKERS COMPENSATION INSURANC	XIX D	37,086	
	HOSPITALIZATION INSURANCE	XIX D	80,463	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,259	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	21,797	
	CHICAGO HEAD TAX	XIX D	0	373,876
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,839	1,839
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	100	
			0	
			0	100
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		442	442
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		165,296	165,296
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,346,073

OAK PARK HEALTHCARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	210,220
LESS SALES TAX	(607)
NET FOOD	209,613
TOTAL PATIENT CENSUS	49,917
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	149751
ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	10950

PATIENT MEALS	149751
ADD EMPLOYEE MEALS	10950
TOTAL MEALS/YEAR	160701
NET FOOD	209613
DIVIDE TOTAL MEALS/YEAR	160701
COST PER MEAL	1.3
TIME EMPLOYEE MEALS	10950
EMPLOYEE MEAL RECLASSIFICATION	14235

OAK PARK HEALTHCARE CENTER
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S										5,867,073	
		NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT		2,067,643	373,876	396,965	82,860	437,118	921,654	111,691	1,551,268		2,519,189
ADJUSTMENTS:											
	EQUIPMENT RENTAL/AUTO LEASE	31,677		11,189			25,956		(68,822)		
	CABLE TV			0			0				
	CONTRACT NURSING										1,482
	INTEREST INCOME							(1)			
	NET VENDING COMMISSIONS							(800)			
	EMPLOYEE PHYSICAL EXAMS		0				0				
	INSURANCE - EXECUTIVE LIFE		0				0				
	MANAGEMENT FEES						0		0		
	O2 INCOME							(17,348)			
	BAD DEBTS						0	0			
	DISCOUNTS LOST							0			
	ANCILLARIES	360,379							0		
	SETTLEMENT INTEREST										
	RECLASSED SALARIES	(69,916)	0	0	0	0	69,916	0	0		
	PROFIT SHARING	0	0	0	0	0	0	0	0		
	PRIOR EXPENSES	0	0	0	0	0	0	(94,940)	0		
	BENEFITS REBILLED	0	0	0	0	0	0	0	0		
	RENT/INTEREST	0	0	0	0	0	0	0	0		
	NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS		2,389,783	373,876	408,154	82,860	437,118	1,017,526	(1,398)	1,482,446	6,190,365	2,520,671
PER FINANCIAL STATEMENTS		2,389,783	373,876	408,154	82,860	437,118	1,017,526	(1,398)	1,482,446	(323,292)	2,520,671
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS										(323,292)	

OAK PARK HEALTHCARE CENTER - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		74,460			74,460			0	74664		
CENSUS DAYS		49,917			57,718			(7,801)	60211		
OCCUPANCY %		67.04%			77.52%				80.64%		
SALARIES											
TOTAL General Services	8-1	442,153	7.17%	8.86	466410	7.36%	8.08	(24,257)	452263	7.35%	7.51
Social Services	12-1	94,862	1.54%	1.90	102432	1.62%	1.77	(7,570)	114232	1.86%	1.90
TOTAL Health Care and Programs	16-1	1,877,300	30.43%	37.61	2127831	33.59%	36.87	(250,531)	2180182	35.41%	36.21
Clerical & General Office Expenses	21-1	81,962	1.33%	1.64	93702	1.48%	1.62	(11,740)	87986	1.43%	1.46
TOTAL General Administration	28-1	199,736	3.24%	4.00	189781	3.00%	3.29	9,955	199058	3.23%	3.31
TOTAL Operation Expense	29-1	2,519,189	40.84%	50.47	2784022	43.95%	48.23	(264,833)	2831503	45.99%	47.03
ADJUSTED TOTALS											
Food	2-8	195,378	3.17%	3.91	237922	3.76%	4.12	(42,544)	213521	3.47%	3.55
Heat and Other Utilities	5-8	123,035	1.99%	2.46	133130	2.10%	2.31	(10,095)	121763	1.98%	2.02
Maintenance	6-8	112,057	1.82%	2.24	133801	2.11%	2.32	(21,744)	150734	2.45%	2.50
TOTAL General Services	8-8	915,216	14.84%	18.33	1018555	16.08%	17.65	(103,339)	977712	15.88%	16.24
Administrative	17-8	171,576	2.78%	3.44	154832	2.44%	2.68	16,744	171077	2.78%	2.84
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	91,179	1.48%	1.83	51902	0.82%	0.90	39,277	44488	0.72%	0.74
Fees, Subscriptions, Promotions	20-8	58,067	0.94%	1.16	39503	0.62%	0.68	18,564	30535	0.50%	0.51
License Fee-IDPA	Pg21	200	0.00%	0.00	0	0.00%	0.00	200	0	0.00%	0.00
License Fee-Other	Pg21	2,258	0.04%	0.05	4279	0.07%	0.07	(2,021)	3805	0.06%	0.06
Clerical & General Office Expenses	21-8	194,941	3.16%	3.91	208678	3.29%	3.62	(13,737)	205675	3.34%	3.42
Employee Benefits & Payroll Taxes	22-8	388,111	6.29%	7.78	438375	6.92%	7.60	(50,264)	444817	7.22%	7.39
Payroll Taxes	Pg21	232,271	3.77%	4.65	246577	3.89%	4.27	(14,306)	261612	4.25%	4.34
W/C Insurance	Pg21	37,086	0.60%	0.74	55268	0.87%	0.96	(18,182)	47053	0.76%	0.78
Health Insurance	Pg21	80,463	1.30%	1.61	88238	1.39%	1.53	(7,775)	84711	1.38%	1.41
Inservice Training & Education	23-8	2,858	0.05%	0.06	557	0.01%	0.01	2,301	3710	0.06%	0.06
Travel and Seminar	24-8	508	0.01%	0.01	1472	0.02%	0.03	(964)	129	0.00%	0.00
Other Admin. Staff Transportation	25-8	3,320	0.05%	0.07	2741	0.04%	0.05	579	1914	0.03%	0.03
Insurance-Prop.Liab.Malpractice	26-8	169,626	2.75%	3.40	115803	1.83%	2.01	53,823	70955	1.15%	1.18
Other (specify):*	27-8	39,986	0.65%	0.80	44180	0.70%	0.77	(4,194)	30433	0.49%	0.51
TOTAL General Administration	28-8	1,120,172	18.16%	22.44	1058043	16.70%	18.33	62,129	1003733	16.30%	16.67
TOTAL Operation Expense	29-8	4,136,653	67.06%	82.87	4436482	70.03%	76.86	(299,829)	4360319	70.81%	72.42
Real Estate Taxes	33-3	353,218	5.73%	7.08	306135	4.83%	5.30	47,083	286203	4.65%	4.75
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	6,168,317	100.00%	**123.57**	6335222	100.00%	**109.76**	(166,905)	6157390	100.00%	**102.26**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1746167.6	28.31%	**34.98**	1741547.5	27.49%	**30.17**	4,620	1638947.7	26.62%	**27.22**

OAK PARK HEALTHCARE CENTER - DIAGNOSTICS - 12/31/2002

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 1904 from Page 22 and -1587 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-33384 MGMT CO 33384
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-13607 MGMT CO 13607
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 = Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 DOES NOT EQUAL Page 21-B. NO MGMT FEES
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.